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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Elias F. Sanchez, M.D. 6780 Indiana Avenue #110 Riverside, CA 92506 Physician's and Surgeon's Certificate No. A 67841, Respondent.	Case No. 800-2016-019959 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about March 19, 1999, the Board issued Physician's and Surgeon's Certificate Number A 67841 to Elias F. Sanchez, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following

laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting

the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 3502 of the Code states:

"(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

"(b)(1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

"(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

"(c)(1) A physician assistant and his or her supervising physician and surgeon shall

establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

"(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

"(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow up care.

"(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

"(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

"(2)(A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

"(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

"(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and

surgeon and the physician assistant.

"(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

"(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

"(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

"(d) No medical services may be performed under this chapter in any of the following areas:

"(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

"(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

"(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

"(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

"(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

"(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations."

8. Section 3502.1 of the Code states:

"(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) 'Drug order,' for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to 'prescription' in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

"(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name,

address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

"(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

"(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the

California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

"(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient."

9. California Code of Regulations, title 16, section 1399.545, states:

"(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

"(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

"(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

"(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

"(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

"(1) Examination of the patient by a supervising physician the same day as care is given by

the physician assistant;

"(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

"(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

"(4) Other mechanisms approved in advance by the board.

"(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence-Patient 1)

10. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent with respect to the care and treatment of Patient 1. The circumstances are as follows:

11. On or about January 31, 2014, Respondent began treating Patient 1, a then two-year-

old male with an initial diagnosis of developmental delay, lead exposure, and allergic rhinitis. Patient 1 had been diagnosed by a previous physician as having an elevated lead level of 20. The Department of Public Health had also been notified in November of 2013 about Patient 1's lead exposure and toxicity. It investigated the source of exposure and followed Patient 1's lead levels. By the time Respondent began seeing Patient 1, Patient 1's lead level had dropped to 9.

12. On or about February 6, 2014, Respondent began treating Patient 1's lead toxicity with Dimercaptosuccinic acid[1] ("DMSA") rectal suppositories. On or about June 17, 2014, Patient 1's lead level was less than 3, but Respondent continued him on DMSA suppositories. On or about September 16, 2014, Respondent again prescribed DMSA suppositories.

13. The Department of Public Health continued to follow Patient 1's lead levels until they dropped to 3 on or about August 18, 2014. During the time that it followed Patient 1's lead levels, the Department's lead poisoning expert did not recommend chelation therapy, a medical procedure that involves the administration of chelating agents (such as DMSA) to remove heavy metals from the body. On or about December 15, 2014, the Department of Public Health closed its case because Patient's 1 blood lead level remained under 15 ug/dL for at least six months.

14. Approximately one year later, on or about December 7, 2015, Respondent wrote a prescription for DMSA suppositories to be done daily for three days, then a multimineral daily for eleven days, then repeat cycle, with six refills. On or about January 18, 2016, Respondent stopped providing care and treatment to Patient 1.

15. Respondent committed an extreme departure from the standard of care when he (a) treated a lead level that was dropping and that did not require treatment, and (b) when he treated Patient 1 with DMSA rectal suppositories. Treatment of lead toxicity in children with a chelating agent (such as DMSA) is indicated for a lead level that is above 45. The standard of care is to administer DMSA in children via an intravenous route or orally, not rectally. Lowering Patient 1's lead level below 9 would not have improved the patient's developmental delays.

16. Respondent's acts and/or omissions as set forth in paragraphs 11 through 15, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute

[1] DMSA is a medication used to treat lead, mercury, and arsenic poisoning.

grossly negligent acts pursuant to Code section 2234, subdivision (b), with respect to the care and treatment of Patient 1. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts-Patients 1, 2, 3, 4, & 5)

17. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated negligent acts with respect to the care and treatment of patients 1, 2, 3, 4, and 5. The circumstances are as follows:

Patient 1

18. The facts and allegations in Paragraphs 11 through 15, above, are incorporated by reference and re-alleged as if fully set forth herein.

19. From on or about February 6, 2014, through on or about January 18, 2016, Respondent ordered blood and stool tests. On or about March 24, 2014, he noted in Patient 1's medical records that he was treating elevated ammonia levels and related them to constipation. Based on the patient's history, it does appear that the patient was constipated. Respondent appropriately prescribed lactulose, magnesium oxide, Benefiber, probiotics, and dietary changes.

20. However, Respondent used tests not indicated in the diagnosis of constipation. Ammonia levels are not indicated for the diagnosis or treatment of constipation in children. Respondent ordered unnecessary blood tests to follow ammonia levels. The ammonia levels did not need to be treated.

21. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 1 as follows:

22. Respondent departed from the standard of care when he (a) treated a lead level that was dropping and that did not require treatment, and (b) when he treated Patient 1 with DMSA rectal suppositories. Treatment of lead toxicity in children with a chelating agent (such as DMSA) is indicated for a lead level that is above 45. The standard of care is to administer DMSA in children via an intravenous route or orally, not rectally. Lowering Patient 1's lead level below 9 would not have improved the patient's developmental delays.

23. Respondent departed from the standard of care when he used tests not indicated in the

diagnosis or treatment of constipation.

Patient 2

24. From on or about February 5, 2012, through on or about January 11, 2013, Respondent treated Patient 2, a then sixty-eight-year-old female. He treated her for chronic pain, osteoarthritis, depression, dementia, anxiety, hypertension, hyperthyroidism, bladder prolapse, and other conditions.

25. During a visit with Respondent on or about February 9, 2012, Patient 2's blood pressure was documented as 156/82. At a follow up visit on or about April 17, 2012, her blood pressure was documented as 150/82. At a follow up visit on or about June 4, 2012, her blood pressure was documented as 172/86. During those three visits, Patient 2's blood pressure was elevated above the goal of 140/90. Respondent did not adjust the medication regimen or document that he monitored or addressed the abnormal elevated blood pressure readings.

26. During a visit with Respondent on or about July 2, 2012, Respondent documented a Mini-Mental Status Examination score of 18, diagnosed dementia, and ordered an MRI and neurology consultation. At the next visit on or about August 3, 2012, he prescribed memantine (Namenda)[2] 10 mg QHS (every bedtime). However, the standard of care is to initiate treatment with memantine 5 mg daily and titrate as tolerated to 10 mg twice daily over a period of 4 weeks.

27. On or about February 20, 2013, Patient 2 died of acute hydrocodone intoxication. Prior to her death, she had a history of drug overdose. On or about June 25, 2011, she was hospitalized for altered mental status as a result of consuming multiple medications, including narcotics and benzodiazepines. On or about July 26, 2012, she was hospitalized for overdose with ibuprofen. Two months later, on or about September 4, 2012, she was hospitalized for benzodiazepine and opiate overdose. She had a history of multiple suicide gestures, suicidal ideation, and suicide attempts.

28. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 2 as follows:

[2] Memantine (Namenda) reduces the actions of chemicals in the brain that may contribute to the symptoms of Alzheimer's disease. Memantine is used to treat moderate to severe dementia of the Alzheimer's type. It may also be used for other purposes.

29. Respondent departed from the standard of care when he failed to address abnormally elevated blood pressure readings during three visits on or about February 9, 2012, April 17, 2012, and June 4, 2012.

30. Respondent departed from the standard of care when he initiated memantine at an elevated dose and then failed to titrate or assess for titration to the target dose.

31. Respondent departed from the standard of care when he failed to more actively pursue management options with Patient 2's son, boyfriend, and community resources for a patient with long-standing benzodiazepine and opiate use, medication overdoses, and suicide attempts who was subsequently diagnosed with moderate dementia (a progressive cognitive illness). Respondent made one Adult Protective Services ("APS") referral and one Home Health safety check referral. He could have made a second APS referral and a second Home Health referral. Respondent should have made multiple attempts to engage the patient's son and boyfriend to discuss options for medication administration, options for hired caregivers for gaps in caregiving, or other solutions such as an assisted living facility with medication administration, a board and care, and/or skilled nursing facilities. He should have also documented any such conversations regarding this patient at high risk for medication error.

Patient 3

32. On or about July 19, 2013, Respondent (via a Physician Assistant) began providing care and treatment to Patient 3, a then fifty-year-old female who had a history of depression, psoriasis, and leg edema, and who was following up from an urgent care visit for edema. Patient 3 was already taking alprazolam[3] and the Physician Assistant refilled the prescription. On or about September 24, 2013, Respondent saw Patient 3 for a follow up. In late 2013, Respondent prescribed Phentermine[4] for weight loss.

[3] Benzodiazepines are a class of drugs that produce Central Nervous System depression and are most commonly used to treat insomnia and anxiety. They are a type of medication known as tranquilizers. Examples of benzodiazepines include alprazolam (e.g., Xanax), lorazepam (e.g., Ativan), and diazepam (e.g., Valium). They are classified as Schedule IV controlled substances as defined by section 1308.14(c) of Title 21 of the Code of Federal Regulations and California Health and Safety Code section 11057, subdivision (d). They are dangerous drugs as defined in Business and Professions Code section 4022.

[4] Phentermine is similar to an amphetamine. It is used together with diet and exercise to

33. Respondent treated Patient 3 over the ensuing two or more years. During that time period, Respondent prescribed alprazolam, sertraline,[5] and carisoprodol.[6] Patient 3 was off and on Phentermine. She received the controlled substances without documentation of a controlled substances contract, monitoring with urine drug tests, or perusal of the Controlled Substance Utilization Review and Evaluation System ("CURES").[7] In addition, there was very little history provided regarding the reasons for the prescribing of controlled substances or any functional assessment or evaluation of the efficacy of the prescriptions.

34. Patient 3 received carisoprodol for an extended period of time. Carisoprodol is a muscle relaxer and is not intended for long-term usage and has many drug interactions. For example, both carisoprodol and alprazolam may cause drowsiness.

35. On or about May 26, 2015, Respondent diagnosed Patient 3 with euthyroid sick syndrome. He prescribed Armour thyroid.[8] However, Patient 3's thyroid function was tested several times via blood testing and all of her results were normal. Euthyroid sick syndrome refers to abnormal thyroid hormone levels seen in very ill patients. The treatment for this condition is to treat the underlying illness and to not provide supplemental thyroid hormone.

36. At all relevant times, Respondent and his Physician Assistants jointly provided care and treatment to Patient 3, including but not limited to, prescribing medications (including controlled substances) to them. Respondent supervised the Physician Assistants. As the

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treat obesity. Phentermine is a Schedule IV controlled substances as defined by 21 Code of Federal Regulations part 1308.14(f)(9) and California Health and Safety Code section 11057, subdivision (f)(4). It is a dangerous drug as defined in Business and Professions Code section 4022.

[5] Sertraline is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs).

[6] Carisoprodol (Soma) is a muscle-relaxant and sedative. Effective January 11, 2012, Carisoprodol is classified as a Schedule IV controlled substance as defined by section 1308.14, subdivision (c)(6) of Title 21 of the Code of Federal Regulations. It is a dangerous drug as defined in Business and Professions Code section 4022.

[7] CURES refers to the Controlled Substance Utilization Review and Evaluation System, which is a government database containing information on Schedule II through IV controlled substances dispensed in California.

[8] Armour Thyroid is desiccated porcine thyroid hormone. It is a prescription medicine that is used to treat a condition called hypothyroidism from any cause, except for cases of temporary hypothyroidism, which is usually associated with an inflammation of the thyroid (thyroiditis). It is meant to replace or supplement a hormone that is usually made by the thyroid gland. It may also be used for other purposes.

supervising physician, Respondent is responsible for all medical services and medications provided by the Physician Assistants to Patient 3 under his supervision.

37. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 3 as follows:

38. Respondent departed from the standard of care when he prescribed and refilled alprazolam and carisoprodol in the absence of an adequate initial history and periodic reassessments of the need and efficacy of the medications.

39. Patient 3 received prescriptions for medications including controlled substances from Physician Assistants on more than one occasion. There is no evidence that the Physician Assistants were prescribing and treating Patient 3 based on any pre-approved formulary and protocols from which the Physician Assistants could prescribe controlled substances. Respondent departed from the standard of care in his supervision of the Physician Assistants' prescribing of controlled substances without patient-specific authorization in the absence of a written practice-specific formulary and protocols that specify all the criteria for the use of a particular drug and any contraindications.

40. Respondent departed from the standard of care when he diagnosed Patient 3 with euthyroid sick syndrome.

41. Respondent departed from the standard of care when he prescribed Armour thyroid at all, and for a patient with normal thyroid function values.

Patient 4

42. On or about April 19, 2011, Respondent (via a Physician Assistant) began providing care and treatment to Patient 4, a then thirty-eight-year-old male. During the initial visit, the patient requested refills of carisoprodol, hydrocodone/acetaminophen,[9] and diazepam for chronic low back pain. The Physician Assistant refilled carisoprodol and hydrocodone/acetaminophen without evidence of any discussion with or review by Respondent.

[9] Hydrocodone/Acetaminophen (Norco, Lortab, Vicodin) is an opioid pain medication. It is a Schedule II controlled substance as defined by section 1308.12, subdivision (b)(1)(vi) of Title 21 of the Code of Federal Regulations and California Health and Safety Code section 11055, subdivision (b)(1)(I). It is a dangerous drug as defined in Business and Professions Code section 4022.

43. After the initial visit, Patient 4 was seen once or twice a year through 2014. From 2015, through 2017, Patient 4 was seen more often. Respondent saw Patient 4 in August of 2012 and June of 2013. The remainder of the visits were with Physician Assistants.

44. Respondent's medical records for Patient 4 reflect little in the way of interim history, functional assessment documentation, or objective exam findings. In spite of this, Patient 4 received refills of carisoprodol and hydrocodone/acetaminophen from Physician Assistants without being seen by Respondent. He continued to receive refills of those controlled substances, including an average of six tablets of hydrocodone/acetaminophen a day and four tablets of carisoprodol a day through 2017.

45. Until on or about December 2017, there is no documentation in Respondent's medical records for Patient 4 reflecting review by or discussion with Respondent concerning the care and treatment rendered by the Physician Assistants to Patient 4. There is no documentation of any case review by Respondent or any signoffs/cosigning of the patient notes by Respondent.

46. There is no evidence that the Physician Assistants were prescribing and treating Patient 4 based on a pre-approved formulary and protocols from which the Physician Assistants could prescribe controlled substances.

47. At all relevant times, Respondent and his Physician Assistants jointly provided care and treatment to Patient 4, including but not limited to, prescribing medications (including controlled substances) to them. As the supervising physician, Respondent is responsible for all medical services and medications provided by the Physician Assistants to Patient 4 under his supervision.

48. Respondent committed repeated negligent acts with respect to the care and treatment of Patient 4 as follows:

49. Respondent departed from the standard of care in his supervision of the Physician Assistants' care and treatment of Patient 4.

Patient 5

50. On or about August 28, 2012, Respondent provided care and treatment to Patient 5, a then sixty-five-year-old female who was a long time patient of his. The visit was for a two-month

follow up. Patient 5 had a history of memory loss and chronic pain. Her current medications at that time included alprazolam 1 mg every 8 hours and carisoprodol 350 mg twice a day.

51. On or about December 28, 2012, Respondent saw Patient 5. Hydrocodone/acetaminophen was listed as a current medication in Respondent's medical records for the patient. It is unclear who prescribed hydrocodone/acetaminophen and when it was prescribed. Respondent refilled the hydrocodone/acetaminophen while Patient 5 was already on carisoprodol and a benzodiazepine. There was no assessment of functional status, pain inventory, controlled substance contract, or evidence of consulting CURES. The physical exam documented did not discuss any tenderness or reveal any objective evidence of pain. Respondent started or re-filled hydrocodone/acetaminophen 10/325 at a relatively high dose of two pills four times a day (with six refills).

52. During a visit on or about February 26, 2013, Respondent documented that the patient was dependent on narcotics. He refilled hydromorphone 8 mg.[10] It is unclear when and by whom hydromorphone was started. Respondent also refilled hydrocodone/acetaminophen, carisoprodol, and alprazolam.

53. By on or about June 12, 2014, Respondent refilled hydromorphone, hydrocodone/acetaminophen, carisoprodol, and alprazolam. He also prescribed two similar anticonvulsants used for chronic pain (pregabalin and gabapentin), an anxiolytic (buspirone), an antidepressant (bupropion), and a medication for insomnia (zolpidem).[11]

54. On or about February 26, 2015, Patient 5 was seen for follow up of a nervous breakdown. Respondent discontinued gabapentin, buspirone, and baclofen.

55. On or about April 24, 2015, Respondent diagnosed Patient 5 with euthyroid sick syndrome and prescribed Armour thyroid hormone supplement. However, Patient 5 had normal

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[10] Hydromorphone (Dilaudid) is an opioid pain medication. It is a Schedule II controlled substance as defined by section 1308.12, subdivision (b)(1)(vii) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11055, subdivision (b)(1)(J). It is a dangerous drug as defined in Business and Professions Code section 4022.

[11] Zolpidem (Ambien) is a sedative. It is a Schedule IV controlled substance as defined by section 1308.14(c)(54) of Title 21 of the Code of Federal Regulations and Health and Safety Code section 11057, subdivision (c)(32). It is a dangerous drug as defined in Business and Professions Code section 4022.

thyroid function values.

56. In or around July 13, 2015, Patient 5 was hospitalized for a drug overdose. Respondent ceased prescribing certain controlled substances (narcotics and other mind altering drugs) to her. On or about January 12, 2016, Respondent referred the patient to pain management. On or about March 14, 2017, Respondent last treated Patient 5.

57. Respondent committed the following repeated negligent acts with respect to the care and treatment of Patient 5:

58. Respondent departed from the standard of care when he prescribed and refilled carisoprodol, a narcotic, a benzodiazepine, and other sedating agents to Patient 5 in the absence of an adequate history and periodic reassessments of the need and efficacy of the medications.

59. Respondent departed from the standard of care when he diagnosed Patient 5 with euthyroid sick syndrome.

60. Respondent departed from the standard of care when he prescribed Armour thyroid at all, and for a patient with normal thyroid function values.

61. Respondent departed from the standard of care in his medical record keeping for Patients 3, 4, and 5. Respondent's notes were generally lacking in details of the subjective complaint. Review of systems for many visits of varying types and varying presenting symptoms were identical or similar, and appear to have been a template or defaulted. For almost every visit across the multiple patients with varying presenting symptoms, the exams documented were identical and contained elements that would not generally be performed for the presenting complaint.

62. Respondent's acts and/or omissions as set forth in paragraphs 18 through 61, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to Code section 2234, subdivision (c), with respect to the care and treatment of patients 1, 2, 3, 4, and 5. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping-Patients 1, 2, 3, 4, & 5)

63. Respondent is subject to disciplinary action under Code section 2266 in that

Respondent failed to maintain adequate and accurate medical records with respect to Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

64. The facts and allegations in Paragraphs 11 through 15 and Paragraphs 18 through 61, above, are incorporated by reference and re-alleged as if fully set forth herein.

65. Respondent's acts and/or omissions as set forth in Paragraphs 11 through 15 and Paragraphs 18 through 61, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate and inaccurate record keeping pursuant to Code section 2266 with respect to Patients 1, 2, 3, 4, and 5. Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct Patients 1, 2, 3, 4, & 5)

66. Respondent is subject to disciplinary action under Code section 2234 for unprofessional conduct with respect to the care and treatment of patients 1, 2, 3, 4, and 5. The circumstances are as follows:

67. The facts and allegations in Paragraphs 10 through 65, above, are incorporated by reference and re-alleged as if fully set forth herein.

68. Respondent's acts and/or omissions as set forth in Paragraph 10 through 65, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to Code section 2234 with respect to the care and treatment of patients 1, 2, 3, 4, and 5. Therefore, cause for discipline exists.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 67841, issued to Respondent Elias F. Sanchez, M.D.;

2. Revoking, suspending or denying approval of Respondent Elias F. Sanchez, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Elias F. Sanchez, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: December 18, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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